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| MEDICAL SERVICE AND SUPPLY REQUEST | | | <input type="checkbox"/> MLC <input type="checkbox"/> MC <input type="checkbox"/> IHA | | 1. DATE OF REQUEST | 2. REQUEST NUMBER |
| | | | 3. TO: <i>(Name and Address of DFAO)</i> Chief, Yokosuka Defense Facilities Administration Office | | | 4. FROM: <i>(Name of Organization)</i> |
| 5. NAME OF EMPLOYEE(S) | 5a. AGE | 5b. JOB TITLE(S) | 5c. PASS NUMBER(S) | 5d. WORK NUMBER(S) | | |
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| 6. TYPE(S) OF MEDICAL SERVICES OR SUPPLIES REQUIRED <i>(Specify)</i> | | | | | | |
| | | | | | | |
| 7. REMARKS | | | | | | |
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| 8. REQUESTED BY <i>(Typed Name & Grade)</i> | | | 9. SIGNATURE | | 10. PHONE NUMBER | |
| 11. COR OR PERSONNEL OFFICER <i>(Typed Name & Grade)</i> | | | 12. SIGNATURE | | 13. DATE | |
| INDORSEMENT BY DFAO | | | | | | |
| 14. REQUESTED MEDICAL SERVICES OR SUPPLIES FURNISHED BY <i>(Typed Name of Chief DFAO)</i> | | | 15. SIGNATURE | | 16. DATE | |